

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9889

CERTIFICATE OF DEATH

09884

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>22 hours</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Brum</u> Last <u>mell</u>			4. DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Merrett Brummell</u>			14. MOTHER'S MAIDEN NAME <u>Rachel Anne Moore</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Ellen Mary Brummell</u> Address <u>Easton, Md.</u>			18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic peritonitis</u> <u>561.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Portion of gangrenous ileum</u> DUE TO (c) <u>Incarcerated hernia</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:40</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Washington ST 154157</u> DATE SIGNED <u>Easton 16, Maryland</u>					
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.					
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>9/5/57</u>		<u>Royal Oak Cem</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
<u>James B. Harwell, Easton, Md.</u>		<u>Easton, Md.</u>		DATE <u>9/5/57</u>	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE			
<u>N.H. Neekie</u>		<u>N.H. Neekie</u>			

CERTIFICATE OF DEATH

RECEIVED

SEP 6 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09885

9890

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> 05X2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Butler</u>		4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Butler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rash</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Elizabeth Butler (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>B.P. 14</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/26</u> , 19 <u>57</u> , to <u>9/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/30</u> , 19 <u>57</u> , and that death occurred at <u>10:15 p.m.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Cox</u>		DATE SIGNED <u>Easton Ind</u>	
PHYSICIAN'S NAME (Type) _____ M.D. _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 4, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Virgil Moore</u>		24a. REC'D BY REGISTRAR DATE <u>10/4/57</u>	
ADDRESS <u>Denton Ind</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newnes</u>	

CERTIFICATE OF DEATH

BUREAU V. E.

OCT 7 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long woods</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>ROWENS</u> Last <u>Collier</u>		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>12</u> Hours <u>12</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Rowens</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stroud</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-11-11-11-11</u>	
17. INFORMANT <u>Mississine Collier (husband)</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Infarction, anterior</u> DUE TO (c) <u>Arteriosclerotic Disease, generalized</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>38 hrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>38 hrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-25</u> , 19 <u>57</u> , to <u>9-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-26</u> , 19 <u>57</u> , and that death occurred at <u>7:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ludwig J. Eglseider</u> M.D.		ADDRESS (Street, city or town, state) <u>12 North Hansen St., Easton Md.</u>	
PHYSICIAN'S NAME (Type) <u>LUDWIG J. EGLSEIDER</u>		DATE SIGNED <u>9-28-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>	22d. LOCATION (City, town, or county) (State) <u>EASTON MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Cawth</u>		24a. REC'D. BY REGISTRAR <u>N.H. Neekes</u>	
ADDRESS <u>Easton, Md.</u>		DATE <u>9/28/57</u>	

CERTIFICATE OF DEATH

FILE NO.

DATE

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF INTERMENT	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL SOCIETY	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF MINISTERS		23. SIGNATURE OF MUSICIANS		24. SIGNATURE OF FLORISTS	
25. SIGNATURE OF COFFIN MAKERS		26. SIGNATURE OF CARRIAGE DRIVERS		27. SIGNATURE OF BELLMEN	
28. SIGNATURE OF URBAN SHERIFFS		29. SIGNATURE OF RURAL SHERIFFS		30. SIGNATURE OF JAILERS	
31. SIGNATURE OF PRISONERS		32. SIGNATURE OF DEPORTED		33. SIGNATURE OF NATURALIZED	
34. SIGNATURE OF CITIZENS		35. SIGNATURE OF RESIDENTS		36. SIGNATURE OF VISITORS	
37. SIGNATURE OF EMPLOYEES		38. SIGNATURE OF EMPLOYERS		39. SIGNATURE OF MANAGERS	
40. SIGNATURE OF SUPERVISORS		41. SIGNATURE OF ASSISTANTS		42. SIGNATURE OF CLERKS	
43. SIGNATURE OF BOOKKEEPERS		44. SIGNATURE OF ACCOUNTANTS		45. SIGNATURE OF AUDITORS	
46. SIGNATURE OF TAXPayers		47. SIGNATURE OF RECEIPTS		48. SIGNATURE OF PAYMENTS	
49. SIGNATURE OF DEBITORS		50. SIGNATURE OF CREDITORS		51. SIGNATURE OF BANKERS	
52. SIGNATURE OF MERCHANTS		53. SIGNATURE OF WHOLESALE		54. SIGNATURE OF RETAIL	
55. SIGNATURE OF IMPORTERS		56. SIGNATURE OF EXPORTERS		57. SIGNATURE OF SHIPPERS	
58. SIGNATURE OF CARRIERS		59. SIGNATURE OF FREIGHT		60. SIGNATURE OF PASSENGERS	
61. SIGNATURE OF STEVEDORES		62. SIGNATURE OF TUGBOATS		63. SIGNATURE OF SAILORS	
64. SIGNATURE OF MARINERS		65. SIGNATURE OF FISHERMEN		66. SIGNATURE OF HUNTERS	
67. SIGNATURE OF TRAPERS		68. SIGNATURE OF FARMERS		69. SIGNATURE OF LABORERS	
70. SIGNATURE OF WORKERS		71. SIGNATURE OF MACHINISTS		72. SIGNATURE OF ENGINEERS	
73. SIGNATURE OF MECHANICS		74. SIGNATURE OF ELECTRICIANS		75. SIGNATURE OF PLUMBERS	
76. SIGNATURE OF PAINTERS		77. SIGNATURE OF CARPENTERS		78. SIGNATURE OF JOINERS	
79. SIGNATURE OF MILLWRIGHTS		80. SIGNATURE OF BLACKSMITHS		81. SIGNATURE OF COWBOYS	
82. SIGNATURE OF RANGERS		83. SIGNATURE OF SHERIFFS		84. SIGNATURE OF JAILERS	
85. SIGNATURE OF PRISONERS		86. SIGNATURE OF DEPORTED		87. SIGNATURE OF NATURALIZED	
88. SIGNATURE OF CITIZENS		89. SIGNATURE OF RESIDENTS		90. SIGNATURE OF VISITORS	
91. SIGNATURE OF EMPLOYEES		92. SIGNATURE OF EMPLOYERS		93. SIGNATURE OF MANAGERS	
94. SIGNATURE OF SUPERVISORS		95. SIGNATURE OF ASSISTANTS		96. SIGNATURE OF CLERKS	
97. SIGNATURE OF BOOKKEEPERS		98. SIGNATURE OF ACCOUNTANTS		99. SIGNATURE OF AUDITORS	
100. SIGNATURE OF TAXPAYERS		101. SIGNATURE OF RECEIPTS		102. SIGNATURE OF PAYMENTS	
103. SIGNATURE OF DEBITORS		104. SIGNATURE OF CREDITORS		105. SIGNATURE OF BANKERS	
106. SIGNATURE OF MERCHANTS		107. SIGNATURE OF WHOLESALE		108. SIGNATURE OF RETAIL	
109. SIGNATURE OF IMPORTERS		110. SIGNATURE OF EXPORTERS		111. SIGNATURE OF SHIPPERS	
112. SIGNATURE OF CARRIERS		113. SIGNATURE OF FREIGHT		114. SIGNATURE OF PASSENGERS	
115. SIGNATURE OF STEVEDORES		116. SIGNATURE OF TUGBOATS		117. SIGNATURE OF SAILORS	
118. SIGNATURE OF MARINERS		119. SIGNATURE OF FISHERMEN		120. SIGNATURE OF HUNTERS	
121. SIGNATURE OF TRAPERS		122. SIGNATURE OF FARMERS		123. SIGNATURE OF LABORERS	
124. SIGNATURE OF WORKERS		125. SIGNATURE OF MACHINISTS		126. SIGNATURE OF ENGINEERS	
127. SIGNATURE OF MECHANICS		128. SIGNATURE OF ELECTRICIANS		129. SIGNATURE OF PLUMBERS	
130. SIGNATURE OF PAINTERS		131. SIGNATURE OF CARPENTERS		132. SIGNATURE OF JOINERS	
133. SIGNATURE OF MILLWRIGHTS		134. SIGNATURE OF BLACKSMITHS		135. SIGNATURE OF COWBOYS	
136. SIGNATURE OF RANGERS		137. SIGNATURE OF SHERIFFS		138. SIGNATURE OF JAILERS	
139. SIGNATURE OF PRISONERS		140. SIGNATURE OF DEPORTED		141. SIGNATURE OF NATURALIZED	
142. SIGNATURE OF CITIZENS		143. SIGNATURE OF RESIDENTS		144. SIGNATURE OF VISITORS	
145. SIGNATURE OF EMPLOYEES		146. SIGNATURE OF EMPLOYERS		147. SIGNATURE OF MANAGERS	
148. SIGNATURE OF SUPERVISORS		149. SIGNATURE OF ASSISTANTS		150. SIGNATURE OF CLERKS	
151. SIGNATURE OF BOOKKEEPERS		152. SIGNATURE OF ACCOUNTANTS		153. SIGNATURE OF AUDITORS	
154. SIGNATURE OF TAXPAYERS		155. SIGNATURE OF RECEIPTS		156. SIGNATURE OF PAYMENTS	
157. SIGNATURE OF DEBITORS		158. SIGNATURE OF CREDITORS		159. SIGNATURE OF BANKERS	
160. SIGNATURE OF MERCHANTS		161. SIGNATURE OF WHOLESALE		162. SIGNATURE OF RETAIL	
163. SIGNATURE OF IMPORTERS		164. SIGNATURE OF EXPORTERS		165. SIGNATURE OF SHIPPERS	
166. SIGNATURE OF CARRIERS		167. SIGNATURE OF FREIGHT		168. SIGNATURE OF PASSENGERS	
169. SIGNATURE OF STEVEDORES		170. SIGNATURE OF TUGBOATS		171. SIGNATURE OF SAILORS	
172. SIGNATURE OF MARINERS		173. SIGNATURE OF FISHERMEN		174. SIGNATURE OF HUNTERS	
175. SIGNATURE OF TRAPERS		176. SIGNATURE OF FARMERS		177. SIGNATURE OF LABORERS	
178. SIGNATURE OF WORKERS		179. SIGNATURE OF MACHINISTS		180. SIGNATURE OF ENGINEERS	
181. SIGNATURE OF MECHANICS		182. SIGNATURE OF ELECTRICIANS		183. SIGNATURE OF PLUMBERS	
184. SIGNATURE OF PAINTERS		185. SIGNATURE OF CARPENTERS		186. SIGNATURE OF JOINERS	
187. SIGNATURE OF MILLWRIGHTS		188. SIGNATURE OF BLACKSMITHS		189. SIGNATURE OF COWBOYS	
190. SIGNATURE OF RANGERS		191. SIGNATURE OF SHERIFFS		192. SIGNATURE OF JAILERS	
193. SIGNATURE OF PRISONERS		194. SIGNATURE OF DEPORTED		195. SIGNATURE OF NATURALIZED	
196. SIGNATURE OF CITIZENS		197. SIGNATURE OF RESIDENTS		198. SIGNATURE OF VISITORS	
199. SIGNATURE OF EMPLOYEES		200. SIGNATURE OF EMPLOYERS		201. SIGNATURE OF MANAGERS	
202. SIGNATURE OF SUPERVISORS		203. SIGNATURE OF ASSISTANTS		204. SIGNATURE OF CLERKS	
205. SIGNATURE OF BOOKKEEPERS		206. SIGNATURE OF ACCOUNTANTS		207. SIGNATURE OF AUDITORS	
208. SIGNATURE OF TAXPAYERS		209. SIGNATURE OF RECEIPTS		210. SIGNATURE OF PAYMENTS	
211. SIGNATURE OF DEBITORS		212. SIGNATURE OF CREDITORS		213. SIGNATURE OF BANKERS	
214. SIGNATURE OF MERCHANTS		215. SIGNATURE OF WHOLESALE		216. SIGNATURE OF RETAIL	
217. SIGNATURE OF IMPORTERS		218. SIGNATURE OF EXPORTERS		219. SIGNATURE OF SHIPPERS	
220. SIGNATURE OF CARRIERS		221. SIGNATURE OF FREIGHT		222. SIGNATURE OF PASSENGERS	
223. SIGNATURE OF STEVEDORES		224. SIGNATURE OF TUGBOATS		225. SIGNATURE OF SAILORS	
226. SIGNATURE OF MARINERS		227. SIGNATURE OF FISHERMEN		228. SIGNATURE OF HUNTERS	
229. SIGNATURE OF TRAPERS		230. SIGNATURE OF FARMERS		231. SIGNATURE OF LABORERS	
232. SIGNATURE OF WORKERS		233. SIGNATURE OF MACHINISTS		234. SIGNATURE OF ENGINEERS	
235. SIGNATURE OF MECHANICS		236. SIGNATURE OF ELECTRICIANS		237. SIGNATURE OF PLUMBERS	
238. SIGNATURE OF PAINTERS		239. SIGNATURE OF CARPENTERS		240. SIGNATURE OF JOINERS	
241. SIGNATURE OF MILLWRIGHTS		242. SIGNATURE OF BLACKSMITHS		243. SIGNATURE OF COWBOYS	
244. SIGNATURE OF RANGERS		245. SIGNATURE OF SHERIFFS		246. SIGNATURE OF JAILERS	
247. SIGNATURE OF PRISONERS		248. SIGNATURE OF DEPORTED		249. SIGNATURE OF NATURALIZED	
250. SIGNATURE OF CITIZENS		251. SIGNATURE OF RESIDENTS		252. SIGNATURE OF VISITORS	
253. SIGNATURE OF EMPLOYEES		254. SIGNATURE OF EMPLOYERS		255. SIGNATURE OF MANAGERS	
256. SIGNATURE OF SUPERVISORS		257. SIGNATURE OF ASSISTANTS		258. SIGNATURE OF CLERKS	
259. SIGNATURE OF BOOKKEEPERS		260. SIGNATURE OF ACCOUNTANTS		261. SIGNATURE OF AUDITORS	
262. SIGNATURE OF TAXPAYERS		263. SIGNATURE OF RECEIPTS		264. SIGNATURE OF PAYMENTS	
265. SIGNATURE OF DEBITORS		266. SIGNATURE OF CREDITORS		267. SIGNATURE OF BANKERS	
268. SIGNATURE OF MERCHANTS		269. SIGNATURE OF WHOLESALE		270. SIGNATURE OF RETAIL	
271. SIGNATURE OF IMPORTERS		272. SIGNATURE OF EXPORTERS		273. SIGNATURE OF SHIPPERS	
274. SIGNATURE OF CARRIERS		275. SIGNATURE OF FREIGHT		276. SIGNATURE OF PASSENGERS	
277. SIGNATURE OF STEVEDORES		278. SIGNATURE OF TUGBOATS		279. SIGNATURE OF SAILORS	
280. SIGNATURE OF MARINERS		281. SIGNATURE OF FISHERMEN		282. SIGNATURE OF HUNTERS	
283. SIGNATURE OF TRAPERS		284. SIGNATURE OF FARMERS		285. SIGNATURE OF LABORERS	
286. SIGNATURE OF WORKERS		287. SIGNATURE OF MACHINISTS		288. SIGNATURE OF ENGINEERS	
289. SIGNATURE OF MECHANICS		290. SIGNATURE OF ELECTRICIANS		291. SIGNATURE OF PLUMBERS	
292. SIGNATURE OF PAINTERS		293. SIGNATURE OF CARPENTERS		294. SIGNATURE OF JOINERS	
295. SIGNATURE OF MILLWRIGHTS		296. SIGNATURE OF BLACKSMITHS		297. SIGNATURE OF COWBOYS	
298. SIGNATURE OF RANGERS		299. SIGNATURE OF SHERIFFS		300. SIGNATURE OF JAILERS	
301. SIGNATURE OF PRISONERS		302. SIGNATURE OF DEPORTED		303. SIGNATURE OF NATURALIZED	
304. SIGNATURE OF CITIZENS		305. SIGNATURE OF RESIDENTS		306. SIGNATURE OF VISITORS	
307. SIGNATURE OF EMPLOYEES		308. SIGNATURE OF EMPLOYERS		309. SIGNATURE OF MANAGERS	
310. SIGNATURE OF SUPERVISORS		311. SIGNATURE OF ASSISTANTS		312. SIGNATURE OF CLERKS	
313. SIGNATURE OF BOOKKEEPERS		314. SIGNATURE OF ACCOUNTANTS		315. SIGNATURE OF AUDITORS	
316. SIGNATURE OF TAXPAYERS		317. SIGNATURE OF RECEIPTS		318. SIGNATURE OF PAYMENTS	
319. SIGNATURE OF DEBITORS		320. SIGNATURE OF CREDITORS		321. SIGNATURE OF BANKERS	
322. SIGNATURE OF MERCHANTS		323. SIGNATURE OF WHOLESALE		324. SIGNATURE OF RETAIL	
325. SIGNATURE OF IMPORTERS		326. SIGNATURE OF EXPORTERS		327. SIGNATURE OF SHIPPERS	
328. SIGNATURE OF CARRIERS		329. SIGNATURE OF FREIGHT		330. SIGNATURE OF PASSENGERS	
331. SIGNATURE OF STEVEDORES		332. SIGNATURE OF TUGBOATS		333. SIGNATURE OF SAILORS	
334. SIGNATURE OF MARINERS		335. SIGNATURE OF FISHERMEN		336. SIGNATURE OF HUNTERS	
337. SIGNATURE OF TRAPERS		338. SIGNATURE OF FARMERS		339. SIGNATURE OF LABORERS	
340. SIGNATURE OF WORKERS		341. SIGNATURE OF MACHINISTS		342. SIGNATURE OF ENGINEERS	
343. SIGNATURE OF MECHANICS		344. SIGNATURE OF ELECTRICIANS		345. SIGNATURE OF PLUMBERS	
346. SIGNATURE OF PAINTERS		347. SIGNATURE OF CARPENTERS		348. SIGNATURE OF JOINERS	
349. SIGNATURE OF MILLWRIGHTS		350. SIGNATURE OF BLACKSMITHS		351. SIGNATURE OF COWBOYS	
352. SIGNATURE OF RANGERS		353. SIGNATURE OF SHERIFFS		354. SIGNATURE OF JAILERS	
355. SIGNATURE OF PRISONERS		356. SIGNATURE OF DEPORTED		357. SIGNATURE OF NATURALIZED	
358. SIGNATURE OF CITIZENS		359. SIGNATURE OF RESIDENTS		360. SIGNATURE OF VISITORS	
361. SIGNATURE OF EMPLOYEES		362. SIGNATURE OF EMPLOYERS		363. SIGNATURE OF MANAGERS	
364. SIGNATURE OF SUPERVISORS		365. SIGNATURE OF ASSISTANTS		366. SIGNATURE OF CLERKS	
367. SIGNATURE OF BOOKKEEPERS		368. SIGNATURE OF ACCOUNTANTS		369. SIGNATURE OF AUDITORS	
370. SIGNATURE OF TAXPAYERS		371. SIGNATURE OF RECEIPTS		372. SIGNATURE OF PAYMENTS	
373. SIGNATURE OF DEBITORS		374. SIGNATURE OF CREDITORS		375. SIGNATURE OF BANKERS	
376. SIGNATURE OF MERCHANTS		377. SIGNATURE OF WHOLESALE		378. SIGNATURE OF RETAIL	
379. SIGNATURE OF IMPORTERS		380. SIGNATURE OF EXPORTERS		381. SIGNATURE OF SHIPPERS	
382. SIGNATURE OF CARRIERS		383. SIGNATURE OF FREIGHT		384. SIGNATURE OF PASSENGERS	
385. SIGNATURE OF STEVEDORES		386. SIGNATURE OF TUGBOATS		387. SIGNATURE OF SAILORS	
388. SIGNATURE OF MARINERS		389. SIGNATURE OF FISHERMEN		390. SIGNATURE OF HUNTERS	
391. SIGNATURE OF TRAPERS		392. SIGNATURE OF FARMERS		393. SIGNATURE OF LABORERS	
394. SIGNATURE OF WORKERS		395. SIGNATURE OF MACHINISTS		396. SIGNATURE OF ENGINEERS	
397. SIGNATURE OF MECHANICS		398. SIGNATURE OF ELECTRICIANS		399. SIGNATURE OF PLUMBERS	
400. SIGNATURE OF PAINTERS		401. SIGNATURE OF CARPENTERS		402. SIGNATURE OF JOINERS	
403. SIGNATURE OF MILLWRIGHTS		404. SIGNATURE OF BLACKSMITHS		405. SIGNATURE OF COWBOYS	
406. SIGNATURE OF RANGERS		407. SIGNATURE OF SHERIFFS		408. SIGNATURE OF JAILERS	
409. SIGNATURE OF PRISONERS		410. SIGNATURE OF DEPORTED		411. SIGNATURE OF NATURALIZED	
412. SIGNATURE OF CITIZENS		413. SIGNATURE OF RESIDENTS		414. SIGNATURE OF VISITORS	
415. SIGNATURE OF EMPLOYEES		416. SIGNATURE OF EMPLOYERS		417. SIGNATURE OF MANAGERS	
418. SIGNATURE OF SUPERVISORS		419. SIGNATURE OF ASSISTANTS		420. SIGNATURE OF CLERKS	
421. SIGNATURE OF BOOKKEEPERS		422. SIGNATURE OF ACCOUNTANTS		423. SIGNATURE OF AUDITORS	
424. SIGNATURE OF TAXPAYERS		425. SIGNATURE OF RECEIPTS		426. SIGNATURE OF PAYMENTS	
427. SIGNATURE OF DEBITORS		428. SIGNATURE OF CREDITORS		429. SIGNATURE OF BANKERS	
430. SIGNATURE OF MERCHANTS		431. SIGNATURE OF WHOLESALE		432. SIGNATURE OF RETAIL	
433. SIGNATURE OF IMPORTERS		434. SIGNATURE OF EXPORTERS		435. SIGNATURE OF SHIPPERS	
436. SIGNATURE OF CARRIERS		437. SIGNATURE OF FREIGHT		438. SIGNATURE OF PASSENGERS	
439. SIGNATURE OF STEVEDORES		440. SIGNATURE OF TUGBOATS		441. SIGNATURE OF SAILORS	
442. SIGNATURE OF MARINERS		443. SIGNATURE OF FISHERMEN		444. SIGNATURE OF HUNTERS	
445. SIGNATURE OF TRAPERS		446. SIGNATURE OF FARMERS		447. SIGNATURE OF LABORERS	
448. SIGNATURE OF WORKERS		449. SIGNATURE OF MACHINISTS		450. SIGNATURE OF ENGINEERS	
451. SIGNATURE OF MECHANICS		452. SIGNATURE OF ELECTRICIANS		453. SIGNATURE OF PLUMBERS	
454. SIGNATURE OF PAINTERS		455. SIGNATURE OF CARPENTERS		456. SIGNATURE OF JOINERS	
457. SIGNATURE OF MILLWRIGHTS		458. SIGNATURE OF BLACKSMITHS		459. SIGNATURE OF COWBOYS	
460. SIGNATURE OF RANGERS		461. SIGNATURE OF SHERIFFS		462. SIGNATURE OF JAILERS	
463. SIGNATURE OF PRISONERS		464. SIGNATURE OF DEPORTED		465. SIGNATURE OF NATURALIZED	
466. SIGNATURE OF CITIZENS		467. SIGNATURE OF RESIDENTS		468. SIGNATURE OF VISITORS	
469. SIGNATURE OF EMPLOYEES		470. SIGNATURE OF EMPLOYERS		471. SIGNATURE OF MANAGERS	
472. SIGNATURE OF SUPERVISORS		473. SIGNATURE OF ASSISTANTS		474. SIGNATURE OF CLERKS	
475. SIGNATURE OF BOOKKEEPERS		476. SIGNATURE OF ACCOUNTANTS		477. SIGNATURE OF AUDITORS	
478. SIGNATURE OF TAXPAYERS		479. SIGNATURE OF RECEIPTS		480. SIGNATURE OF PAYMENTS	
481. SIGNATURE OF DEBITORS		482. SIGNATURE OF CREDITORS		483. SIGNATURE OF BANKERS	
484. SIGNATURE OF MERCHANTS		485. SIGNATURE OF WHOLESALE		486. SIGNATURE OF RETAIL	
487. SIGNATURE OF IMPORTERS		488. SIGNATURE OF EXPORTERS		489. SIGNATURE OF SHIPPERS	
490. SIGNATURE OF CARRIERS		491. SIGNATURE OF FREIGHT		492. SIGNATURE OF PASSENGERS	
493. SIGNATURE OF STEVEDORES		494. SIGNATURE OF TUGBOATS		495. SIGNATURE OF SAILORS	
496. SIGNATURE OF MARINERS		497. SIGNATURE OF FISHERMEN		498. SIGNATURE OF HUNTERS	
499. SIGNATURE OF TRAPERS		500. SIGNATURE OF FARMERS		501. SIGNATURE OF LABORERS	
502. SIGNATURE OF WORKERS		503. SIGNATURE OF MACHINISTS		504. SIGNATURE OF ENGINEERS	
505. SIGNATURE OF MECHANICS		506. SIGNATURE OF ELECTRICIANS		507. SIGNATURE OF PLUMBERS	
508. SIGNATURE OF PAINTERS		509. SIGNATURE OF CARPENTERS		510. SIGNATURE OF JOINERS	
511. SIGNATURE OF MILLWRIGHTS		512. SIGNATURE OF BLACKSMITHS		513. SIGNATURE OF COWBOYS	
514. SIGNATURE OF RANGERS		515. SIGNATURE OF SHERIFFS		516. SIGNATURE OF JAILERS	
517. SIGNATURE OF PRISONERS		518. SIGNATURE OF DEPORTED		519. SIGNATURE OF NATURALIZED	
520. SIGNATURE OF CITIZENS		521. SIGNATURE OF RESIDENTS		522. SIGNATURE OF VISITORS	
523. SIGNATURE OF EMPLOYEES		524. SIGNATURE OF EMPLOYERS		525. SIGNATURE OF MANAGERS	
526. SIGNATURE OF SUPERVISORS		527. SIGNATURE OF ASSISTANTS		528. SIGNATURE OF CLERKS	
529. SIGNATURE OF BOOKKEEPERS		530. SIGNATURE OF ACCOUNTANTS		531. SIGNATURE OF AUDITORS	
532. SIGNATURE OF TAXPAYERS		533. SIGNATURE OF RECEIPTS		534. SIGNATURE OF PAYMENTS	
535. SIGNATURE OF DEBITORS		536. SIGNATURE OF CREDITORS		537. SIGNATURE OF BANKERS	
538. SIGNATURE OF MERCHANTS		539. SIGNATURE OF WHOLESALE		540. SIGNATURE OF RETAIL	
541. SIGNATURE OF IMPORTERS		542. SIGNATURE OF EXPORTERS		543. SIGNATURE OF SHIPPERS	
544. SIGNATURE OF CARRIERS		545. SIGNATURE OF FREIGHT		546. SIGNATURE OF PASSENGERS	
547. SIGNATURE OF STEVEDORES		548. SIGNATURE OF TUGBOATS		549. SIGNATURE OF SAILORS	
550. SIGNATURE OF MARINERS		551. SIGNATURE OF FISHERMEN		552. SIGNATURE OF HUNTERS	
553. SIGNATURE OF TRAPERS		554. SIGNATURE OF FARMERS		555. SIGNATURE OF LABORERS	
556. SIGNATURE OF WORKERS		557. SIGNATURE OF MACHINISTS		558. SIGNATURE OF ENGINEERS	
559. SIGNATURE OF MECHANICS		560. SIGNATURE OF ELECTRICIANS		561. SIGNATURE OF PLUMBERS	
562. SIGNATURE OF PAINTERS		563. SIGNATURE OF CARPENTERS		564. SIGNATURE OF JOINERS	
565. SIGNATURE OF MILLWRIGHTS		566. SIGNATURE OF BLACKSMITHS		567. SIGNATURE OF COWBOYS	
568. SIGNATURE OF RANGERS		569. SIGNATURE OF SHERIFFS		570. SIGNATURE OF JAILERS	
571. SIGNATURE OF PRISONERS		572. SIGNATURE OF DEPORTED		573. SIGNATURE OF NATURALIZED	
574. SIGNATURE OF CITIZENS		575. SIGNATURE OF RESIDENTS		576. SIGNATURE OF VISITORS	
577. SIGNATURE OF EMPLOYEES		578. SIGNATURE OF EMPLOYERS		579. SIGNATURE OF MANAGERS	
580. SIGNATURE OF SUPERVISORS		581. SIGNATURE OF ASSISTANTS		582. SIGNATURE OF CLERKS	
583. SIGNATURE OF BOOKKEEPERS		584. SIGNATURE OF ACCOUNTANTS		585. SIGNATURE OF AUDITORS	
586. SIGNATURE OF TAXPAYERS		587. SIGNATURE OF RECEIPTS		588. SIGNATURE OF PAYMENTS	
589. SIGNATURE OF DEBITORS		590. SIGNATURE OF CREDITORS		591. SIGNATURE OF BANKERS	
592. SIGNATURE OF MERCHANTS		593. SIGNATURE OF WHOLESALE		594. SIGNATURE OF RETAIL	
595. SIGNATURE OF IMPORTERS		596. SIGNATURE OF EXPORTERS		597. SIGNATURE OF SHIPPERS	
598. SIGNATURE OF CARRIERS		599. SIGNATURE OF FREIGHT		600. SIGNATURE OF PASSENGERS	
601. SIGNATURE OF STEVEDORES		602. SIGNATURE OF TUGBOATS		603. SIGNATURE OF SAILORS	
604. SIGNATURE OF MARINERS		605. SIGNATURE OF FISHERMEN		606. SIGNATURE OF HUNTERS	
607. SIGNATURE OF TRAPERS		608. SIGNATURE OF FARMERS		609. SIGNATURE OF LABORERS	
610. SIGNATURE OF WORKERS		611. SIGNATURE OF MACHINISTS		612. SIGNATURE OF ENGINEERS	
613. SIGNATURE OF MECHANICS		614. SIGNATURE OF ELECTRICIANS		615. SIGNATURE OF PLUMBERS	
616. SIGNATURE OF PAINTERS		617. SIGNATURE OF CARPENTERS		618. SIGNATURE OF JOINERS	
619. SIGNATURE OF MILLWRIGHTS		620. SIGNATURE OF BLACKSMITHS		621. SIGNATURE OF COWBOYS	
622. SIGNATURE OF RANGERS		623. SIGNATURE OF SHERIFFS		624. SIGNATURE OF JAILERS	
625. SIGNATURE OF PRISONERS		626. SIGNATURE OF DEPORTED		627. SIGNATURE OF NATURALIZED	
628. SIGNATURE OF CITIZENS		629. SIGNATURE OF RESIDENTS		630. SIGNATURE OF VISITORS	
631. SIGNATURE OF EMPLOYEES		632. SIGNATURE OF EMPLOYERS		633. SIGNATURE OF MANAGERS	
634. SIGNATURE OF SUPERVISORS		635. SIGNATURE OF ASSISTANTS		636. SIGNATURE OF CLERKS	
637. SIGNATURE OF BOOKKEEPERS		638. SIGNATURE OF ACCOUNTANTS			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9892

CERTIFICATE OF DEATH

09887

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LARRY Middle COLLINS Last COLLINS		4. DATE OF DEATH Month 9 Day 12 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/57
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) yrs. 26 Months 26 Days 26 Hours 26 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME EDWARD F. COLLINS		14. MOTHER'S MAIDEN NAME DORIS FAULKNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 757.3 DUE TO Congenital urethral valve Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 325A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. H. Schmidt M.D.		DATE SIGNED 2195 Westhippen St. 14 Sept 57	
PHYSICIAN'S NAME (Type) E. C. H. Schmidt		ADDRESS (Street, city or town, state) Easton 16, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Sept. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial	22d. LOCATION (City, town, or county) (State) Easton Talbot, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Maurice A. Newman ADDRESS 501 Easton, Md.		24a. REC'D BY REGISTRAR DATE 7/14/57	
		24b. REGISTRAR'S SIGNATURE M. A. Newman	

CERTIFICATE OF DEATH

1957

BUREAU V. S.

SEP 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9893

CERTIFICATE OF DEATH

09888

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>				c. LENGTH OF STAY IN 1b <u>47 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Copper</u> Last <u>Jr.</u>				4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 5 1904</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Richard Copper, Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>Iida Mooney</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. West 1129 St</u> DATE SIGNED <u>9-9-57</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS <u>Easton MD, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>9/9/57</u>		<u>Copperville Cemetery</u>		<u>Easton MD, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Wadswell</u>				24a. REG'D BY REGISTRAR <u>9/9/57</u> 24b. REGISTRAR'S SIGNATURE <u>M.A. Nelson</u>			

CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, date, and cause of death.

BUREAU V. R.

SEP 13 1957

RECEIVED

1957 09 13 10 57 AM

9894

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>"Moreling Chance"</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Barthett Dixon Cullen</u>				4. DATE OF DEATH Month Day Year <u>September 5 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9 1892</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>10 27</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Thomas Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ondesluyon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Mrs. Kenny Willis Easton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>H. C. V. D.</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>9/5/57</u> , that I last saw the deceased alive on <u>9/4/57</u> , and that death occurred at <u>5 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>B. Cop</u> M.D. <u>Easton Md</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u>				24a. RECEIVED BY REGISTRAR <u>1085 Harwood St</u>		24b. REGISTRAR'S SIGNATURE <u>N. A. Newman</u>	
ADDRESS <u>Easton Md</u>				DATE <u>9/7/57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 17 1957

BUREAU V. S.

9895

CERTIFICATE OF DEATH

09890

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>40 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>G.</u> Last <u>Duling</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 18, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John F. Duling</u>		14. MOTHER'S MAIDEN NAME <u>Laura Russell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr Russell E Duling</u>	
17. INFORMANT <u>Mr Russell E Duling</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of</u> (c) <u>Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1st</u> , 19 <u>57</u> , to <u>Sept 3rd</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 3rd</u> , 19 <u>57</u> , and that death occurred at <u>9:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		DATE SIGNED <u>219 S. Washington St. Sept 3rd 1957</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton 16, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore 7, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witke</u>		ADDRESS <u>4101 Edmonden</u>	
24a. REC'D BY REGISTRAR <u>9/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Nesbitt</u>	

BUREAU W. A.

SEP 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 7 10-11-57 et 9896 CERTIFICATE OF DEATH

09891

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>J</u> Middle <u>Planner</u> Last <u>ELLIOTT</u>				4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 19 1860</u>		9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Mary Norton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Lola Harris (Daughter)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO <u>Arteriosclerosis - generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 months</u> DUE TO (c) <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>September 19 1957</u> to <u>9/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>57</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. V. Palmer</u>				ADDRESS (Street, city or town, state) <u>Easton, Md</u>		DATE SIGNED <u>9/30/57</u>	
PHYSICIAN'S NAME (Type) <u>M. V. PALMER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Wed. Sept. 30 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Smith</u> ADDRESS <u>Easton Maryland</u>				24a. REC'D BY REGISTRAR <u>9/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	

BUREAU V. B.

NOT 17 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle L. Last FAIRBANK		4. DATE OF DEATH Month September Day 28 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1872
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Retail Food	
11. BIRTHPLACE (State or foreign country) St. Michaels, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver T. Fairbank		14. MOTHER'S MAIDEN NAME Rachel Lednum	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 215-14-3008	
17. INFORMANT Mrs. Lawrence Fairbank, St. Michaels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction Immediate DUE TO arteriosclerotic coronary heartd. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-21 , 1956 , to 9-28 , 1957 , that I last saw the deceased alive on 9-27 , 1957 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) St Michaels Md DATE SIGNED 9-30-57 ACTUAL SIGNATURE Wm M Reeser Jr M.D. St Michaels Md PHYSICIAN'S NAME (Type) Wm M Reeser Jr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 1, 1957	
22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hamilton Harrison, St Michaels, Md		24a. REC'D BY REGISTRAR Oct 1 57	
24b. REGISTRAR'S SIGNATURE W. Hamilton Harrison			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

OCT 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09893
9907
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LYDIA Middle S. Last GBORGE				4. DATE OF DEATH Month September Day 25 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1868	9. AGE (In years last birthday) 89 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME William Richardson				
14. MOTHER'S MAIDEN NAME Mary B. Hunt			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --				
16. SOCIAL SECURITY NO. None			17. INFORMANT Newton George, Avalon P.O., Maryland Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4x1.4 DUE TO anorexia malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (multiple renal cysts) DUE TO Symptomatic renal cysts (c) Chronic renal failure						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 3 weeks 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----						WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)		(State)		
21. I certify that I attended the deceased from Sept 24, 1957 to Sept 25, 1957 , that I last saw the deceased alive on Sept 24, 1957 , and that death occurred at Tilghman, Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE John M. Pirelser M.D.			DATE SIGNED Sept 26, 1957				
PHYSICIAN'S NAME (Type) JOHN M. PIRELSER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 28, 1957		22c. NAME OF CEMETERY OR CREMATORY St. John's Church Cemetery		22d. LOCATION (City, town, or county) (State) Fairbank, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hambleton Harrison ADDRESS St. Michael's			24a. REC'D BY REGISTRAR med DATE SEP 27 '57		24b. REGISTRAR'S SIGNATURE med		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 27 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please re-
 culate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 far- to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
 or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 290									
1. PLACE OF DEATH a. COUNTY <u>Salbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Exeter</u>					c. LENGTH OF STAY IN 1b <u>5 mos</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>Chester, Md.</u>				
3. NAME OF DECEASED (Type or print) <u>John Lawrence Hammett</u>					4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 21/1938</u>		9. AGE (in years last birthday) <u>18</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chalk</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Mr. Bennie Hammett</u>					14. MOTHER'S MAIDEN NAME <u>Caroline Bedford</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto accident - Fractured skull</u> <u>823 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speed - ran off road and overturned</u>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9</u> p. m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State road</u>									
20f. (City or town) <u>hr. Centreville</u> (County) <u>A</u> (State) <u>Md.</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>W. Henry Fisher</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>9/11/57</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE CEMETERY</u>					22d. LOCATION (City, town, or county) <u>STEVENSVILLE MD.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Thompson</u>					24a. REC'D BY REGISTRAR <u>9/10/57</u>				
ADDRESS <u>CHURCH HILL MD.</u>					24b. REGISTRAR'S SIGNATURE <u>N. A. Perkins</u>				

RECEIVED

SEP 1 1977

BUREAU A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9898

CERTIFICATE OF DEATH

09895

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>_____</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>_____</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VIOLA Ruth</u> First Middle Last				4. DATE OF DEATH <u>September 13 1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1898</u> 59 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Corabelle Frampton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CHARLES HORNEY, GRASONVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Abdominal adhesion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>_____</u> DUE TO (c) <u>_____</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				M.D. <u>2195 Washington St. 16 Sept. 57</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton, Md., Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRINGHILL CEMETARY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. CARROLL</u>				ADDRESS <u>EASTON, MD.</u>		24a. REC'D BY REGISTRAR <u>9/16/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>			

BUREAU V. S.

SEP 1 1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09896

9899

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>14 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. Michaels</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>C.</u> Middle <u>Jones</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1889</u> 68 yrs.		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James G. Jones</u>			
14. MOTHER'S MAIDEN NAME <u>Matilda Ross</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT <u>Mrs. Deborah H. Jones (wife)</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary - severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adenocarcinoma, generalized</u> DUE TO (c) <u>metastatic</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 15, 1953</u> to <u>Sept 22, 1957</u> , that I last saw the deceased alive on <u>23 Sept 1957</u> , and that death occurred at <u>10:25 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm M Reese</u> M.D.				ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>9-22-57</u>			
22a. NAME (Type) <u>Wm M Reese</u>				22b. DATE THEREOF <u>9/25/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Bellevue Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>St Michaels Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maureen K. Neumann-Son</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>9/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neuman</u>	

BUREAU V. S.

OCT 2 1917

RECEIVED

09897

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION N. WASHINGTON ST.		d. STREET ADDRESS N. WASHINGTON ST.	
3. NAME OF DECEASED (Type or print) DEBRA LYNN KEENE		4. DATE OF DEATH SEPT 13 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 4 1955
9. AGE (In years lost birthday) 2 yrs.		10. IF UNDER 1 YEAR: Months 13 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT RUSSELL KEENE		14. MOTHER'S MAIDEN NAME SARA SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ALBERT R. KEENE		Address N. WASHINGTON ST. EASTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Febrile Convulsion (Laryngeal spasm) DUE TO (b) Septicemia (Organism not identified) DUE TO (c) 8 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-12-57 , to 9-13-57 , that I last saw the deceased alive on 9-12-57 , and that death occurred at 8 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John E. Baybutt		ADDRESS (Street, city or town, state) 205 Soile Ave. EASTON, MD.	
PHYSICIAN'S NAME (Type) John E. Baybutt		DATE SIGNED 9/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/16/57	
22c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEMETERY		22d. LOCATION (City, town, or county) (State) EASTON MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Gault		ADDRESS EASTON, MD.	
24a. REC'D BY REGISTRAR N. A. Newkirk		24b. REGISTRAR'S SIGNATURE N. A. Newkirk	
DATE 9/16/57			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. R.

SEP 11 1957

RECEIVED

9901

CERTIFICATE OF DEATH

09898
Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>S. AURORA ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADDIE BEBECCA LOVE</u>				4. DATE OF DEATH Month Day Year <u>9/13 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 25, 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>PETER JAMES PATCHETT</u>		14. MOTHER'S MAIDEN NAME <u>CELIA ANN CANNON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-103220</u>		17. INFORMANT <u>MRS. LEWIS CARROLL</u> Address <u>5. AURORA ST. EASTON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL-VASCULAR ACCIDENT</u> <u>301A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>JUNE</u> 19 <u>57</u> to <u>SEPT. 13</u> 19 <u>57</u> , that I last saw the deceased alive on <u>SEPT. 13</u> 19 <u>57</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>9/13/57</u>							
ACTUAL SIGNATURE <u>Donald F. Bartley</u> M.D. <u>9 N. HANSEN ST.</u>							
PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY</u> <u>EASTON MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>PRESTON MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Campbell</u> ADDRESS <u>EASTON, MD</u>				24a. REC'D BY REGISTRAR <u>9/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newkirk</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1957

BUREAU V. A.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9902

CERTIFICATE OF DEATH

09899

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>48 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Margaret</u> Last <u>McGowan</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Vincent De Nicole</u>				14. MOTHER'S MAIDEN NAME <u>Silvia Celotta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mr. Dino McGowan</u>				Address <u>(Son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, ruptured</u> <u>931X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>			
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>10:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE <u>Sept 16 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 16 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, county) (State) <u>St. Michaels, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hamilton Harrison</u>				ADDRESS <u>St. Michaels, Md.</u>			
24a. REC'D BY REGISTRAR <u> </u>				24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>			

RECEIVED

SEP 1 1957

BUREAU V. S.

Reg. Dist. No. 12190

~~9923~~

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON - RURAL</u>		c. LENGTH OF STAY IN 1b <u>1 YR.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"CLIFTON"</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>FRANKLIN</u> Last <u>MULLIKIN</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 21, 1911</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD. ST. DEPT. HEARD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>OSCAR H. MULLIKIN</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE COVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>WWT</u>	
17. INFORMANT <u>MRS. RUTH E. MULLIKIN, CLIFTON MD.</u>		Address <u>CLIFTON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Hypertension & arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July - 57</u> 19____, to <u>9-15</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9-19</u> 19 <u>57</u> and that death occurred at <u>4:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2103 Dover Easton Md.</u> DATE SIGNED <u>9/16/57</u> ACTUAL SIGNATURE <u>William L. Winters</u> M.D. PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u> <u>2103 DOVER EASTON MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TRUCKEE</u>	22d. LOCATION (City, town, or county) <u>MD.</u> (State) _____
23. BUREAU DIRECTOR'S SIGNATURE <u>W. J. [Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>9/17/57</u>	24b. REGISTRAR'S SIGNATURE <u>N. H. [Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST MICHAELS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARRY H. NEAVITT				4. DATE OF DEATH Month Day Year SEPT 14 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 7, 1891	9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY HOUSING		11. BIRTHPLACE (State or foreign country) BOZMAN, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD S. NEAVITT				14. MOTHER'S MAIDEN NAME IDA B. MCQUAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-16-6403		17. INFORMANT Address MRS. HARRY NEAVITT, ST. MICHAELS, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenocarcinoma - Lung Rt. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to (c) as a result of severe							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) metastases - generalized & cerebral							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9-14-57	
20f. (City or town) ST. MICHAELS, MD.				20g. (County) TALBOT		20h. (State) MD.	
21. I certify that I attended the deceased from 9-15-57 to 9-14-57 , that I last saw the deceased alive on 9-14-57 , and that death occurred at 8:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ST. MICHAELS, MD. DATE SIGNED 9-16-57							
ACTUAL SIGNATURE Guy M. Reeser				PHYSICIAN'S NAME (Type) Guy M. Reeser			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 17, 1957		22c. NAME OF CEMETERY OR CREMATORY BOZMAN CEMETERY		22d. LOCATION (City, town, or county) (State) BOZMAN, MD	
23. FUNERAL DIRECTOR'S SIGNATURE L. Hamilton Harrison, St. Michaels				24a. REC'D BY REGISTRAR DATE SEP 17 1957			
24b. REGISTRAR'S SIGNATURE							

BUREAU V. S.

SEP 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

290

9904

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>		d. STREET ADDRESS <u>x1 Wye Mills</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mary</u> Last <u>Victoria Scott</u>		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/1890</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Samuel Wilkerson</u>	
14. MOTHER'S MAIDEN NAME <u>Amanda Thomas</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Anna Victoria Scott (Wife)</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Chronic systemic disease</u> DUE TO (c) <u>fever</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Hour a. s. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>57</u> , to <u>Sept 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>57</u> , and that death occurred at <u>7:00</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. H. Winnacott</u>		ADDRESS (Street, city or town, state) <u>Ridgely, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>A. H. WINNACOTT</u>		DATE SIGNED <u>9/27/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wye Mills</u>	22d. LOCATION (City, town, or county) (State) <u>Wye Mills Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Washell</u>		24a. REC'D BY REGISTRAR <u>N. H. Newlin</u>	
ADDRESS <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. I.

OCT 2 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton</u>		d. STREET ADDRESS <u>Easton</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>PHILIP</u> Last <u>STAFFORD</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 20, 1885</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	9. AGE (In years last birthday) <u>71</u>
13. FATHER'S NAME <u>JOHN WESLEY STAFFORD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
16. SOCIAL SECURITY NO. <u>212-32-541</u>		17. INFORMANT <u>MRS. JOHN P. STAFFORD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Sept 12, 1957</u> to <u>Sept 16, 1957</u> that I last saw the deceased alive on <u>Sept 12, 1957</u> , and that death occurred at <u>9:55</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>F. E. Cox</u> M.D. <u>Easton Md</u> PHYSICIAN'S NAME (Type) <u>F. E. Cox</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>EASTON MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Augustine Groll, Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9/18/57</u>	24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 26 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09905

9910

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Delhat</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> 17x2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Rio Vista Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>EMORY</u> Last <u>TURPIN</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19 - 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Centerville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J.P. Turpin</u>		14. MOTHER'S MAIDEN NAME <u>Anna Emary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ms J R E Turpin Centerville Maryland</u>	
17. INFORMANT <u>Ms J R E Turpin Centerville Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>arteriosclerotic coronary heart d.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 mins</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-30-57</u> , 19 <u>57</u> , to <u>9-23-57</u> , that I last saw the deceased alive on <u>9-23-57</u> , 19 <u>57</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>St Michaels md</u> M.D.		DATE SIGNED <u>9-23-57</u>	
PHYSICIAN'S NAME (Type) <u>Wm M Reeser Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept 24-57</u>	<u>Leont Ness Family Plot</u>	<u>Centerville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Smith</u>		ADDRESS <u>Centerville Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 25 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Reeser</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 25 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>G</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1903</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William T. Wood</u>			
14. MOTHER'S MAIDEN NAME <u>Ida Leonard</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Frances Wood - wife</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis left hem. / reg.</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that I attended the deceased from <u> </u> 19 <u>48</u> to <u>25 Sept</u> 19 <u>57</u> , that I last saw the deceased alive on <u>22 Sept</u> 19 <u>57</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. <u> </u>				ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>27 Sept 57</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> 22b. DATE THEREOF <u>Sept 28, 57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u> 22d. LOCATION (City, town, or county) <u>Easton</u> (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>N.H. Neekes</u>		DATE <u>9/28/57</u>	

BUREAU V. S.

OCT 7 1957

RECEIVED

CERTIFICATE OF DEATH

9912

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of funeral director	
13. Signature of medical examiner		14. Signature of coroner		15. Signature of jury	
16. Signature of health officer		17. Signature of local health officer		18. Signature of state health officer	
19. Signature of federal health officer		20. Signature of federal health officer		21. Signature of federal health officer	
22. Signature of federal health officer		23. Signature of federal health officer		24. Signature of federal health officer	
25. Signature of federal health officer		26. Signature of federal health officer		27. Signature of federal health officer	
28. Signature of federal health officer		29. Signature of federal health officer		30. Signature of federal health officer	
31. Signature of federal health officer		32. Signature of federal health officer		33. Signature of federal health officer	
34. Signature of federal health officer		35. Signature of federal health officer		36. Signature of federal health officer	
37. Signature of federal health officer		38. Signature of federal health officer		39. Signature of federal health officer	
40. Signature of federal health officer		41. Signature of federal health officer		42. Signature of federal health officer	
43. Signature of federal health officer		44. Signature of federal health officer		45. Signature of federal health officer	
46. Signature of federal health officer		47. Signature of federal health officer		48. Signature of federal health officer	
49. Signature of federal health officer		50. Signature of federal health officer		51. Signature of federal health officer	
52. Signature of federal health officer		53. Signature of federal health officer		54. Signature of federal health officer	
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